Busey (S. C.)

Alternating Anterior and Posterior Version of the Uterus.

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WASHINGTON, D. C.

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ALTERNATING ANTERIOR AND POSTERIOR VERSION OF THE UTERUS.

BY SAMUEL C. BUSEY, M. D.,
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THE above title has been selected to set forth succinctly and fully the distinctive feature of a case of malposition of the uterus, in which the organ, when unsupported by any mechanical contrivance, was always found in the position either of complete anteversion or retroversion.

The history of this case is as follows: On April 28, 1878, Mrs. —— after a somewhat fatiguing journey reached the city of Washington, and was seen by me, for the first time, on the next day. She was an intelligent and accomplished woman; twenty-nine years of age, above the average height and slender; had been married seven years and borne two children, the elder daughter being six and the younger three and a half years old. Previous to her marriage she had excellent health and was accustomed to active exercise — walking and horseback riding. Menstruation was regular and painless, lasting from five to six days, and usually copious during the second and third days. Her first child was borne eleven months after marriage. Labor was tedious and convalescence tardy. Since then she had never enjoyed vigorous health as formerly; during the inter-pregnant interval she suffered from debility, some pelvic distress, was unable to superintend her household duties, and after any unusual effort was compelled to seek relief in the recumbent posture, being frequently confined to her bed for a week or more. Menstruation, beginning at an indefinite period after the first labor, recurred regularly, but was always accompanied with considerable pelvic pain and head-

ache, continued during a longer period and was greatly increased in quantity. With the commencement of the second pregnancy, her general health improved, but she did not regain the vigor and freshness of her first gestation. The second accouchment was more difficult and protracted than the first, and was followed by a dangerous illness, which continued during several weeks. Since then she had been a confirmed invalid, passing most of her time either in bed or on a lounge. During the year succeeding the last parturition she had not submitted to any systematic medical treatment, but mainly relied upon rest in the recumbent posture, which afforded comparative comfort, except during the catamenia, which returned with regularity, but were attended with augmented suffering and a greatly increased loss of blood, the flow uniformly continuing for nine or ten days. For the past two and a half years she had been constantly under treatment.

She represented that she had suffered from some chronic inflammatory condition and displacement of the womb, and that she had been during several periods, varying from three to six months, subjected to very energetic local treatment, such as the weekly application of caustics which had occasioned severe paroxysms of pain, coming on a few hours after the applications, and only relieved by large doses of morphine. On one occasion, which was not the last, however, after what she supposed had been an unusually severe cauterization, a painful and protracted pelvic trouble had followed, which endangered her life. Pessaries of various shapes had been tried, but none had afforded permanent ease ; the last, a Hoffman's elastic pessary, which had been worn during her journey and for several days preceding her departure from home, had given more comfort than any previously employed.

Her bowels acted irregularly, were usually constipated, but sometimes for several days consecutively she would have one or more loose stools. Defecation was at times painful. Frequent micturition had been only an occasional annoyance. Her appetite was poor and somewhat capricious ;

she had lost flesh, and been much troubled with palpitation, which she feared was the symptom of some severe heart disease. She slept badly, but was markedly free from the psychical and sensory disturbances, which so frequently complicate these chronic uterine ailments. She expressed herself as feeling very greatly improved.

As I found her she was feeble and anemic, had a small compressible and frequent pulse, and complained of con stant pain in the sacral and left iliac regions, which occasionally also invaded the middle and right hypogastrium, was sometimes diffused throughout the pelvis, and at times extended down the thighs. These pains grew worse when she was sitting erect, were greatly aggravated when walking, especially when ascending or descending steps, and were intensified during the periods of menorrhagic discharge, which continued with unabated profuseness. So much were the pains augmented during locomotion that she but rarely attempted to walk, could not dress herself without assistance, and seldom left her chamber, not even joining the family at their meals. There was some tenderness on firm pressure over the left ovary, but it was not marked elsewhere. She had removed the Hoffman pessary the night previous. The vagina was tender and very greatly distended, feeling like an inflated sac, with smooth, moist walls. The cervix uteri was pressing firmly against the anterior vaginal wall, the os looking towards the symphysis pubis. The neck was firm, hard, pale, and felt like cartilage. The body and fundus were correspondingly depressed posteriorly, occupying Douglas' pouch, and pressing against the rectum ; were very tender, but not apparently enlarged. The probe passed with facility to the fundus without producing pain. The organ was movable in every direction ; measured three and one quarter inches, the excess of length being due to elongation of the infra-vaginal cervix. Its longitudinal axis occupied apparently an antero-posterior median direction. There was no discharge through the os, nor was the probe even tinged with blood, notwithstanding the manipulation to determine the mobility of the organ.

In the left lateral cul-de-sac there was moderate tenderness, increased by bi-manual pressure, and a sense of resistance and tension in the direction of the left broad ligament. The left ovary could not be distinctly felt. By pressure with the finger against the anterior surface of the infra-vaginal cervix the organ could be easily restored to its normal position. In effecting reposition the os swept the posterior vaginal wall in firm contact, and, when the uterus was in position, seemed imbedded in its surface. The patient alleged that pain, frequently felt when sitting erect, was relieved by shielding the perineum from pressure. The rectal ampoule contained large masses of feces. The importance of these details will be appreciated when I discuss the causes of the reversible malposition, which as yet had not been suspected.

With this history and these facts before me, the indications for treatment were : —

1. To reduce the displacement and retain the organ in position.

2. To rebuild her wasted physique.

3. To arrest the excessive menstrual losses of blood.

After having communicated the result of the examination and indicated my purpose to adjust an instrument to support the womb, the patient politely informed me that my suggestion was simply the repetition of the old story, and, directing me to where I found a Smith's modification of Hodge's closed lever pessary, added that it had been tried numerous times, without affording relief except at times for a day or two, followed by an aggravation of her discomfort. This protest was disregarded. The instrument was introduced and left. It simply lodged on the floor of the spacious vaginal cavity. With directions to meet the second indication, and to use vaginal injections of hot water morning and night, we parted for the time being. The next day she was less complaining. The vaginal cavity had diminished and the uterus was resting against the posterior arm of the pessary. On the 1st of May the menses began. The flow was excessive and continued during nine days, notwith-

standing the free administration of gallic acid from the close of the fourth day, and rest in bed during the entire period, but was unaccompanied with the usual pelvic pains and headache. She slept well under the influence of a single moderate dose of chloral hydrate each night. She abandoned the bed the day after the cessation of the discharge and next day I found her suffering more than at any time since her arrival. To my great surprise the uterus occupied a right oblique direction, the fundus lying to the right of the median line, against the right ramus of the pubes and the os pointing towards the left sacro-iliac synchondrosis. Unwilling to acknowledge a mistaken diagnosis, I re-adjusted the organ and left the instrument in position. The vaginal cavity had collapsed, and its walls closed around the cervix and the pessary. The following day the organ had resumed its right oblique malposition. The Hodge pattern was abandoned and a Thomas anteflexion instrument substituted.[1] I persisted for some days in attempts to utilize this instrument. My theory was that if I could succeed in stretching or displacing the intervening soft parts and effect close coaptation of the concavity of the body of the apparatus to the cervix, so as to cover the anterior surface of both the infra- and supra-vaginal portions, I might, partially at least, fix the points around which the organ revolved in its movements of anteversion and retroversion. To accomplish this it was necessary to prevent the forward rotation of the infra-vaginal cervix, which must occur in retroversion, and the anterior deviation of the supra-vaginal neck which necessarily took place in anteversion. This I hoped to effect by making the symphysis pubis the fixed base against which the curved extremity of the hinged wing of the support would rest, thus securing uniform coaptation of the partially fixed parts of the womb and pessary, thereby limiting the oscillations of the organ to an arc of safety, be that arc the one described by the os or by the fundus. The surface of impingement should include the anterior face of the organ, extending from the lower margin of the

[1] As described, *Gynecological Transactions*, p. 238, vol. ii., 1877.

attachment of the anterior vaginal wall to the cervix up to and above the level of the internal os, or else flexion might be promoted. The uterus perversely refused to obey my will or to verify my theory. The fundus would either dislodge itself from the excavation of the support and resume its right oblique position or follow the arc of posterior descent, forcing the os into and against the concavity of the body of the pessary. On a single occasion I found the neck riding over the top of the instrument. Reflection since has satisfied me that my failure was attributable as much to the mechanical construction of the apparatus as to any defect in my theory. If I had transferred the joint and attached the movable fulcral wing transversely to the convexity of the body of the instrument on a line corresponding with the axis of the organ in its antero-posterior oscillations, which must be located between the lower vaginal and upper vesical attachments of the anterior surface of the uterus, I might have had better success. To return, however, to the history of the case. Baffled in these efforts, I instituted a series of experimental observations to ascertain the causes of these erratic movements of the viscus, with the following results. When placed in complete retroversion it would remain in that malposition, but when anteverted it invariably either glided into the right oblique position previously described or changed into a retroversion. These demonstrations brought me to the conclusion that several influences were concerned in the causation of these changing relations, — to wit, rectal distention, vesical repletion and collapse, tension of the lower portion of the left broad ligament, the increased length of the organ, elongation and induration of the infra-vaginal cervix, and probable structural changes which added density, hardness, and rigidity to the body and fundus, as was manifestly the case with the infra-vaginal portion. This hyperplastic condition, together with the additional length, rendered effective the resistance of the contiguous structures to the normal backward and forward motions, thus causing deviation of the longitudinal axis in the direction of least resist-

ance. The right oblique position was favored by the conjoint agency of a distended rectum and the abnormal traction occasioned by the increased tension and diminished mobility of the lower border of the left lateral attachments, probably coöperating also with the action of a distended bladder, which would elevate the organ and press backwards the cervix. If then the uterus, thus altered in structure, was lifted up and deviated obliquely through its longitudinal axis from right to left, by the conjoint operation of these several forces, it can be easily understood why the body and fundus should follow the collapse of the bladder and finally rest against the right ramus of the pubes, and also why the organ was constantly dislodged from the Thomas pessary. For inasmuch as the region of the internal os anteriorly is the most firmly fixed portion of the uterus, because of its attachment to the posterior wall of the bladder, the fundus would necessarily follow the changing conditions of that viscus. So that when the organ was lifted up and away from the instrument, with backward and left lateral displacement of the cervix, it would maintain this oblique direction of its long axis in descent following vesical depletion, consequently escaping the excavation of the pessary and resuming the position of right antero-lateral version.

So far the discussion refers to the causation of the oblique malposition, but the case presented other peculiarities which demanded investigation, to which attention is now invited.

When the uterus was placed in complete retroversion it remained so, with its longitudinal axis apparently occupying a median antero-posterior direction, but when restored to the normal position and left without support it might revert to the posterior malposition or assume the position of right antero-lateral version. If left in the latter deviation it would sooner or later return to the condition of retroversion, and if supported in front by the Thomas pessary it would either resume the right antero-lateral or posterior displacement. Various agencies were combined in the

production of these erratic movements, of which the essential factor was the elongated and indurated cervix. Vesical elevation, rectal distention, position of the body, the influence of the changing relations of the pressure of the superincumbent viscera to the longitudinal axis of the womb, and defecation under certain circumstances, were accessory, though subordinate elements.

In examining the *modus operandi* of the lengthened neck in effecting these alternating dislocations, it must not be forgotten that in the reduction of the retroversion the os impinged against the posterior vaginal wall and was imbedded in its surface. The vagina is a "musculo-membranous tube, remarkable for its dilatability." Its posterior surface is irregular, unstable, and crossed by numerous "transverso-curvilinear ridges." At varying parts and under constantly changing conditions it would offer greater or less obstruction to an os sweeping and indenting its surface in its antero-posterior movements, and, accordingly, the neck would deviate backwards or forwards in the direction of lesser resistance. Especially might this occur should any accessory force be simultaneously operative in the opposite direction upon the body or fundus.

The influence of these inconstant relations of the vulvo-uterine canal in determining the direction of the longitudinal axis of the uterus, when increased in length, is not always a passive agency, favoring or facilitating an anterior or posterior displacement, but may become an active force directing the course of the cervical deviation. In the case under review, the womb when left in position would rotate either backwards or forwards, but when supported by a closed lever pessary, the agencies engaged in causing these malpositions were ineffective except in producing version forward. That they were inconstant is shown by the fact that not unfrequently the organ would rest against the instrument behind for several days before the direction of its long axis would be reversed. The dorsal decubitus promotes retroversion. Sitting erect or standing may favor, under varying circumstances, either retroversion or

anteversion, the resulting malposition being determined probably by some auxiliary force. How far posture was instrumental in promoting these alternating versions cannot be determined or even conjectured, but it is not improbable that it was a subsidiary agency secondary only to the elongated cervix.[1] I cannot assert the fact, but the conformation of her figure suggested acquired aggravation of the dorso-lumbar spinal curve, a compensating excessive pelvic obliquity, or vice versa, which would favor, in erect positions of the trunk, forward inclination of the fundus. In this connection it is also worthy of note that the liability to a change of the direction of the version, increased as the longitudinal axis approximated the axis of the superior pelvic strait, owing either to the more direct action of the posterior vaginal wall on the indurated cervix, or to the more effective influence of the accessory forces upon the body and fundus.

The history of the patient does not determine the existence of any developmental defect of formation of the uterus, neither does it exclude the probability of such a condition. The only abnormal symptom attending menstruation previous to her first pregnancy was an excessive duration of the periods. Neither the regularity of the periods, nor their freedom from pain preclude the presence of flexure of the cervix, for Emmet[2] has fixed the proportion of such cases as were regular from the first at 75.36 per cent., and of such as were free from pain at 74.87 per cent. These percentages are increased when the estimate is restricted to those who were fruitful. The same distinguished gynecologist fixes the proportion of those in whom menstruation "remained unchanged in every respect from the condition at the beginning," at 47.37 per cent. of "all the cases with flexures of the cervix," and estimates the average duration of the "cases where the flow was always normal as to quantity" to be 5.04 days. In the cases where the flow was too free, but the time remained

[1] See paper by the author, *Am. J. Obst.*, iv., 585.

[2] *Tr. Am. Gynec. Soc.*, i., 56, 57.

unchanged, the duration was 6.41 days. These data establish the probability that flexure of the cervix did exist prior to the first pregnancy. It is also inferred from the statistics collected by the same writer that lengthened duration, and increase of the quantity, of the flow in after-life, belong to the natural history of such cases, but this circumstance alone would be insufficient to account for the extraordinary prolongation of the periods in the present case.

From his study of the "development and subsequent changes in the different forms of flexures," Dr. Emmet concludes that —

"Flexures of the cervix have their origin at about the age of puberty by the balance being lost between the relative growth of the body and cervix. From the earliest development of the uterus until pregnancy some degree of anteversion exists as a rule. With the uterus in this position the neck cannot be developed to an undue length without forcing the cervix forward in the axis of the vagina where the least resistance is offered. As the body lies forward, the cervix must become bent upon itself at, or near, the vaginal junction, and thus the flexure is formed. This condition must exist or the uterus will become retroverted, the result being determined by the fullness or absence of the posterior cul-de-sac of the vagina. If the cervix is small enough in diameter to be readily bent upon itself, the flexure takes place; but if the contrary be the case and the cul-de-sac be small, retroversion of the organ will occur. As the growth is not always completed at the time of the first menstrual period, a female may begin with flexure of the cervix and afterward from retroversion have retroflexion. With flexure of the cervix, the neck always becomes longer in after life than it was at puberty, from being crowded forward in the vagina, which condition will frequently produce retroversion."

The foregoing considerations brought me to the conclusion that the elongated and cartilaginous cervix was the predominant, if not the essential factor in causing the alternate anterior and posterior versions.

Holding this opinion, three methods of treatment suggested themselves.

1. Amputation of the cervix.
2. Organic fixation of the cervix.
3. Mechanical fixation of the cervix.

To the first, as the primary procedure, there were many objections. The patient had reached the age of average maximum fertility,[1] and pregnancy held out a hope of permanent cure. With an elongated and hyperplastic cervix and probable involvement of the supra-vaginal portion of the organ in the same structural change, pregnancy was not very probable, but the probability would be greatly diminished by amputation of the cervix. Again, it could not be determined, in advance, how necessary the infra-vaginal portion might be to maintain the body and fundus in the healthy position. For, if my theory that the condition of the cervix was the essential instrumentality in producing the alternating versions was incorrect, its amputation might have proven even worse than nugatory. Partial ablation might have obviated these objections, but it was deemed best to hold these procedures in reserve for subsequent developments.

The second method, which proposed to effect attachment of the lateral walls of the vagina to the sides of the cervix, was deemed impracticable for reasons which will appear manifest to the Fellows.

The third and last method remained. This I attempted to carry out with variously devised pessaries. Hoffman's, which had offered comparative comfort, was objectionable because of the material of which it was made which absorbed the secretions; from the difficulty of adjustment; and from its immobility and lateral dilatation of the vagina when in position. I finally succeeded with one of Fowler's instruments, such as is shown in the cut (Fig. 1.). This the patient soon learned to remove and readjust, at pleasure, with remarkable facility. It was removed on retiring and

[1] Duncan, *Fecundity, Fertility, and Sterility*, 2d ed., Edinburgh, 1871, pp. 5, 6.

replaced before rising in the morning. Its greatest measurement corresponded with the axis of the vagina, and unlike Hoffman's, which retained the uterus always in the same position, it admitted, within a limited arc, the antero-posterior oscillations of the organ and lessened the traction upon the left lateral attachments. Thenceforward my patient improved very rapidly, gaining strength, vigor, and flesh.

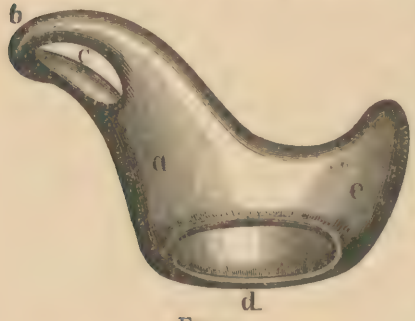

FIG. 1.

Her second menstruation began on June 1st, ceased on the fifth day, and was free from any of the usual accompanying disturbances, without the aid of remedies. The third period commenced on July 1st and lasted five and a half days. During the periods she was kept at rest in the recumbent posture. Fowler's instrument was removed and Hodge's pessary substituted, to prevent posterior descent. The hot water vaginal injections were assiduously employed during the inter-menstrual intervals.

Time and space preclude the recital of the various adjuvants, both therapeutic and dietary, which were employed to rebuild her wasted physique. Suffice it to say they were adapted to the making of "blood and fat," relieving the constipation, and restoring vigor and strength to her constitution. She was anxious and quite willing to return to her home, and on July 9, several days after the cessation of her third menstruation, departed for her home. Later advices report continued improvement.

I apprehend, and so informed her, that the case was not completed. Amputation of the cervix, either partial or complete, may yet have to be performed, or flexure of the body may occur and add its distressing disturbances to her protracted sufferings.

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